No. 2
1-4-
17-39
X26390

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 3 1943

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 15667

Registration District No. 342 Primary Registration District No. 6153 Registrar's No.

1. PLACE OF DEATH:
(a) County: Stoddard
(b) City or town: Rural Route
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: None
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: None (Specify whether
In this community: 19 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 103
(a) State: Missouri (b) County: Stoddard
(c) City or town: Rural
(If outside city or town limits, write "RURAL")
(d) Street No.: Near Bell City, Mo.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: SHERROD G GROSS
3. (b) If veteran, name war: None
3. (c) Social Security No.: None
4. Sex: Male
5. Color or race: Negro
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Lizzie Gross
6. (c) Age of husband or wife if alive: 51 years
7. Birth date of deceased: March (Month) 12 (Day) 1875 (Year)

8. AGE: Years	Months	Days	If less than one day
68	1	12	hr. min.

9. Birthplace: Black Hawk (City, town, or county) Mississippi (State or foreign country)
10. Usual occupation: Farmer
11. Industry or business:
FATHER
12. Name: Sherrod Gross, Sr.
13. Birthplace: Not Known (City, town, or county) Not Known (State or foreign country)
MOTHER
14. Maiden name: Angeline Meeks
15. Birthplace: Not Known (City, town, or county) Not Known (State or foreign country)
16. (a) Informant: Lizzie Gross
(b) Address: Bell City, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof April 28 1943 (Month) (Day) (Year)
(c) Place: burial or cremation: Glenview Rest Home. Bell City, Mo.
18. (a) Signature of funeral director: Chas. S. Morgan
(b) Address: Advance, Mo.
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 28 year 1943 hour 5 minute — 4 M.
21. I hereby certify that I attended the deceased from ..., 19..., to ..., 19...; that I last saw h... alive on ..., 19...; and that death occurred on the date and hour stated above.

Immediate cause of death: High Blood Pressure leading to intra Cranial Hemorrhage — Duration

Due to:

Due to:

Other conditions (Include pregnancy within 3 months of death): —

Major findings: Of operations: — Of autopsy: —

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify): —
(b) Date of occurrence: —
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? — (e) Means of injury: —
23. Signature: C. O. Bennett (M.D.)
Address: Bell City, Mo. Date signed 4/24/43

1131

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by Lloyd S. Morgan, Registered Apprentice No. ..... working under my personal supervision.

Signed Lloyd S Morgan

Licensed Embalmer No. 3361

P. O. Address Advance Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
M—8-21-41
I X29288

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 18-667

Registration District No. 342 Primary Registration District No. 6153 Registrar's No. 8

1. PLACE OF DEATH:

(a) County: S Stoddard

(b) City or town: Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME: Sherrod A. Gross

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex: M

5. Color or race: B

6. (a) Single, widowed, married, divorced: M

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased: March (Month) 12 (Day) 1875 (Year)

8. AGE: Years 68 Months 1 Days 12 If less than one day hr. min.

9. Birthplace: Miss (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 5-27-43 (Date received local registrar) (b) M R Thrower (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April 24 year 1943 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19;

that I last saw h alive on 19;

and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

S-15667